

CERTIFICATE OF VISUAL EXAMINATION
TOP PORTION MUST BE COMPLETED BY APPLICANT

UTAH DRIVER LICENSE DIVISION

FAX NUMBER
(801) 957-8698

For Office Use Only:

- ☐ Private Vehicle Driver
☐ Commercial Vehicle Driver

PO BOX 144501
SLC UT 84114-4501
PHONE NUMBER (801) 965-4437

www.driverlicense.utah.gov

Last Name First Name Middle or Maiden Name Date of Birth Driver License or Driving Privilege Card Number

Street Address City State Zip Code Social Security Number / ITIN

☐ The address above is different from the address showing on my Driver License or Driving Privilege Card.

If you have a commercial license you will need to appear at a commercial driver license office to obtain a new license with your correct address.

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P.O. Box 144501, Salt Lake City, Utah 84114-4501. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information may no longer be protected in accordance with HIPPA but will be classified as a private record in accordance with GRAMA (UCA 63G-2-202). Individuals who are entitled to have a "private" record disclosed to them are limited to the subject of the record, a parent or legal guardian of an unemancipated minor or legally incapacitated individual, an individual with power of attorney or a notarized release signed by the subject of the record, or an individual with a court or legislative subpoena.

Applicant's Signature X:

Date

*** Form will not be processed without signature.***

(Visual Acuity Report and restrictions to be filled out by Health Care Professional.)

Visual Acuity	Are lenses required while driving?		Visual Field 120° 60° to both right and left <u>Private and Commercial</u> CDL COLOR BLIND <input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> No Without Correction	<input type="checkbox"/> Yes With Correction	
RIGHT EYE	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO
LEFT EYE	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO
BOTH EYES	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO

Circle Profile Level: 1 2 3 4 5 6 7 8 9 10 Shaded areas require Medical Advisory Board review

Restrictions: ☐ Speed ☐ Area ☐ Daylight Only ☐ Accompanied by Licensed Driver

☐ YES ☐ NO If visual fields are less than 120°, are they at least 90°, with 45° to both the right and left of fixation?

☐ YES ☐ NO If visual fields are less than 90°, are they at least 60°, with 30° to both the right and left of fixation?

☐ YES ☐ NO Does the patient have diabetes mellitus, cardiac disease, hypertension, or any other systemic disease that may affect driving? _____

Indicate the etiology of the visual impairment: _____

How stable is the visual condition? _____

Recommended interval for examination: ☐ Standard for Profile Level ☐ Other: Specify Interval _____

☐ I recommend this driver complete a driving skills test in an appropriate vehicle.

Date of Examination Printed Name of Health Care Professional Signature and Degree State License Number
(Current within 6 months)

Street Address City State Zip Code Telephone Fax Number

For Office Use Only: DLD Screening

Date of Examination Signature Employee Number Field Station